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Essay

AN ATTITUDE STUDY OF EX-ARMY OPTOMETRISTS CONCERNING THE PRACTICE OF ARMY OPTOMETRY

Submitted by

MARSHALL K. SCHRANTZ
(O.D. Southern College of Optometry, 1954)

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Approved W. L. Treuting

Waldo L. Treuting, M.D.
Professor and Head of Department
of Public Health Practice

University of Pittsburgh

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Unlimited

STATEMENT

Although the author is a Major in the Medical Service Corps of the United States Army Medical Department, the views and opinions expressed are derived from a survey of ex-Army Optometrists, research and analysis of responses, the conclusions drawn from this study are not to be construed as statement of official policy of the Department of the Army or the Department of Defense.

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INTRODUCTION

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INTRODUCTION

The study of the retention problems of the United States Military, particularly of the Army, in retaining Optometrists on active duty has been one that has interested me for many years. This is a problem that "everyone" talks about and a great many people "know all about" but one that little has been done about and to which no serious study has been given. As a career Military Optometrist, this subject was chosen for my Master of Public Health Essay, to try to bring forth the truth of the problem as best it could be determined. It is hoped that the results of this study will provide insight into the problems of retention as seen by the professional who has honorably fulfilled his military obligation, who can express from the point of view of a military practitioner and civilian practitioner, his true feelings without fear of retaliation or hope of personal gain.

The continued loss of experienced personnel in the Army Medical Department decreases the continuity and quality of care that the Department can provide. It is then, imperative that research into the causes of the problem be made and alternatives to the present system be developed to maintain the high quality of care that is associated with the Army Medical Department and is the right of every military man and his family.

This writer has been greatly assisted in this project and wishes to thank Dr. Waldo L. Treuting, Head of the Department of Public Health Practice, University of Pittsburgh, and his staff, Dr. Edmund M. Ricci, Assistant Professor of Sociology, Department of Public Health Practice, with special thanks to Mary Hannaway, Annette Goldman, James Nesbitt and John Grice for their collective efforts in developing, funding, editing and supporting this project.

THE PROBLEM

THE PROBLEM

The United States Military, and particularly the Army, is faced with a monumental problem of how to acquire and maintain an all volunteer force capable of maintaining peace or resisting aggression, anywhere in the world today. Optometry, as a specialty in the Army Medical Department, Medical Service Corps, has come under special attention because of the extremely low retention rates of Optometry Officers upon completion of their military obligation.*

Optometry Officers are procured under the Doctors** Draft Law and the ten Colleges*** of Optometry provide a readily available source of supply in conjunction with the use of this law or the threat of its use. The supply from the draft means that the Army has available "on call" or on active duty, a large number of junior officers. However, this leaves the Army painfully short of middle grade and senior officers experienced in the management of large clinics, such as the basic or advanced individual training centers, experienced research staff, especially in the aeromedical research program, officers with advanced management degrees for the multi-million dollar optical laboratories and senior officers to assume command of the Optometry Section itself. Many clinics where a Lieutenant Colonel is authorized as Chief of the section are considered fortunate to have a Major as chief, and sometimes

* The American Optometric Association, The Department of the Army, Navy and Air Force are all involved in this problem at the present time. The United States House of Representatives and Senate are very much aware of the problem also. A recently passed House Bill and a Senate Bill, not passed at this writing are considering professional pay for optometrists as a possible means of combating this shortage of optometrists and problems of retention.

** Optometrists have faced the draft four of the past five years.

*** There are presently twelve Colleges of Optometry but at this writing, two have not produced their first graduating class. They are expected to produce these classes in the years 1974 and 1975 and will serve to increase the annual number of graduates by 20 percent or more.

these positions have to be filled with Captains who lack the experience and necessary qualifications to properly accomplish the mission.

Table 1*
Optometrists on Active Duty Compared to Optometrists Authorized

N = 286

Rank	Authorized		Actual		
	N	%	N	%	
Colonel	23	8.0	4	1.4	
Lieutenant Colonel	40	14.0	18	6.3	
Major	54	19.0	41	14.3	
Captain	66	23.0	211	70.2	
Lieutenant (Second and First)	103	36.0	0	0.0	
Totals	286	100.0%	274	92.2%	(of authorization)

The problem then has been reduced to: What changes must the Army make in its policies and/or programs that will induce young officers to remain on active duty for a career, so that the health services provided by this group of professionals will not be reduced to an unacceptable level.

There must be some changes that will be sufficient to provide an adequate cadre of middle and senior grade officers to provide a continuing balance of experience and stability, to go along with the exuberance of youth provided by the draft or procured simply by the attractiveness of the programs and the opportunities that are offered.

This is not a new problem but one that is receiving special attention at this time due to the retirement of many optometrists who have provided the

* Department of the Army Statistics, 11 May 1971

core of the Optometry Section for the past twenty years. We are rapidly approaching a time when we will have almost no middle-grade officers, a rapidly turning over junior officer population, and a limited number of senior officers who will be without replacements.

At the present time only 38 of the 211 Captains have over three years military service and several of these are extensions for particular overseas or stateside assignments and therefore at this time cannot be considered career men. Seven of these men have secured regular army commissions and are considered career men. A further analysis of Regular Army Officers will be made later in this paper.

To avoid a continuation of this deficit, there must be changes in the present system. What these changes must be is another matter altogether, and is the purpose of this paper.

THE PROFESSIONAL AND THE BUREAUCRATIC ORGANIZATION

THE PROFESSIONAL AND THE BUREAUCRATIC ORGANIZATION
THE CONCEPTS "ORGANIZATION" AND "PROFESSION"

All organizations face the important problems of securing from their members the commitment, loyalty and cooperation necessary for effective goal attainment. This problem is particularly relevant for the professional personnel. This is so because the professionals have commitments and loyalties to a reference group composed of other professionals and to a definite set of normative standards governing their work, besides the commitment to the organization. These differing sets of commitments are often contradictory and may result in organizational conflicts.[1]

A complex organization may be defined as a large, fairly permanent social system, designed to achieve rather limited objectives, through the coordination of its members. Actually, organizations are inventions of men to achieve control and rational decision-making in the pursuit of a set of specific objectives.

Organizations are made up of people. People come to organizations with different goals. Income, power, status, convenience and security are but a few of the personal needs which organization members may try to satisfy. Therefore they participate in organization affairs with varying loyalty, showing divided loyalty to the (1) organization as a whole, (2) to self, (3) to a specified group (profession) and (4) some narrow organization objectives. These individuals do not always conform to the stated goals of the organization due to the existence of divided loyalties.

Bureaucratic organizations have a system of rules, standards and decision-making structures which are intended to assure that the organization achieves its goals. Workers at the lower organizational levels have little

participation in planning the "means-ends" chains nor do they have much basis for rationally evaluating the effectiveness of the procedures they are asked to carry out. Norms and standards are not internalized so that a system of rules which specifies how the work is to be done will be necessary, and therefore, some workers will have to be given the job of interpreting and enforcing the rules. In addition, the rules and the supervisory personnel must function to coordinate the efforts of the various workers to assure that the several activities will each contribute to the accomplishment of the assigned task.

A profession may be defined as a vocation requiring a long period of formal training to master a body of theoretical as well as applied knowledge and emphasizing a service. Each profession serves the vital needs of man and considers its first ethical imperative to be altruistic service to the client.

A profession has the following characteristics:

(1) sets its own education and training standards.

(2) determines the requirements for admission.

(3) a student accepted, goes through a long period of socialization, isolation, and developes a new identity.

(4) licensure in some form.

(5) legislation concerned with members of the profession is drafted by members of the same profession.

(6) is relatively free of "lay" evaluation and control.

(7) norms of practice are enforced by the profession and are more stringent than legal control.

(8) the profession is most likely a terminal profession.

(9) Welfare of and service to a client is the prime concern of the profession.

(10) honors claims of other professions.[2]

Professions are a community within society, they have peer review and strength in numbers.

The professional in a large bureaucratic organization is a unique individual. He has strong professional ties and prefers to be primarily identified with the profession, rather than with the organization. He strives first of all to attain the goals of the profession, rather than the goals of the organization. The quality of output and the pleasure/satisfaction derived from this output are much more important than the quantity of output which is second in consideration and a poor second at that.

The organization is managed by an administrator, who assisted by his staff understands (1) production figures, (2) patient waiting time, (3) patient complaints. Quality in patient care is not numerically statistical nor quantifiable except remotely in the number of complaints. Often complaints from poor quality do not come forth in a bureaucratic type of medical care: "with free care comes inferior care" attitude many time prevails, so why complain?

Quality, according to Webster's dictionary, is the degree of excellence, or degree of conformance to a standard. Quantity, is defined as a finite amount or number, or the total amount or number, i.e. a measurable attribute.

Quality then is judgment and the administrator has only judgment reports on which to rely, not a data sheet from the comptroller.

Time is then the next variable with which quantity and quality become involved. Until the intelligence and ability to understand become standard among all patients, patient care will involve a variable of time. Two patients with the same problem, same complaint and same required treatment may involve as much as a fifty percent time differential. In military practice, often the niceties and amenities have to be dispensed with entirely, or have to be completed as the patient is being seated. This is avoided wherever possible as

as any health profession in practice is part psychology. To "feel" that one's doctor has contributed his undivided attention, a full examination, and invoked the proper amenities increases the success rate of the practice immensely. (We might at this point wonder why, after 25 years of "success" the professional man is still practicing while the mechanic after a limited amount of time is "fixing" or the construction worker is "building". We just don't "practice" putting up buildings. I realize that "practice" as such is a world wide colloquialism and derives from the days of the "studying under" type of professional training.)

A professional is said to care little for organizational matters that do not impinge upon his area of specialty.[3] These beliefs have led to the development of what has been referred to as the "dual ladder". In simplest terms, the problem appears to be to find a way to reward the professionals for good professional work performance while keeping them involved in professional rather than bureaucratic activities. This is done in many organizations by rewarding them with special prestige, freedom and job luxuries.[4]

Insofar as the traditional system of incentives in organizations prevails, the motivation for the pursuit of a professional career in the organization will be dampened. Professional ladders, whereby professionals can secure advances in salary and status without taking on bureaucratic duties, has become one of the recent experiments in industry. Instead of greater organizational authority, they are rewarded with greater freedom to engage in their professional specialties.[5]

The professional ladder does not provide an organizational arrangement which permits the professionals to share the power necessary to control his organizational affairs. That is its major fault. The lack of power in the

professional ladder comes not so much from the lack of supervisory responsibility over others as from a lack of involvement in the decision-making and power processes of the organization. Promotions to higher positions in the organizations customarily are accompanied by securing more power in the organization and obtaining confidential information.[6]

From this we can easily see that while the optometrists surveyed in this research felt that things were not right and that more time, more equipment and more personnel were a quick solution to their problems it is obvious to make changes, the use of power is necessary. This power comes from the higher echelon in the organization, not at the level of the practitioner-patient relationship, where the important decisions are technical ones. These decisions are extremely important to the individual patient, but the overall structure of the environment in which the practitioner and the patient get together, amount of time and equipment involved or available for use, are not especially individual decisions. The organization, in this instance the Army, must utilize its resources for the entire patient population served, not in any one specialty. If therefore, power lies with administrators, professionals in organizations must exert themselves in this area to insure a fair share of distribution.

THE ARMY AS A BUREAUCRATIC ORGANIZATION

The Army is one of the world's largest bureaucratic organizations and with this are certain inherent problems. First, we might consider the growth and development of the Army.

The Army, following the "BIG WAR", the war to end all wars, World War I, was reduced to a caretaker force of professionals which would provide a nucleus with which to develop a real army, should one "ever" be needed again. This was done again after World War II when the army was reduced below 400,000 personnel.

The civilian image of the professional soldier remains firmly rooted in the past. His style of life, his day-to-day tasks, and his aspirations change as the technology of war is transformed. Yet, outdated and obscure conceptions of the military establishment persist because the civilian society, including the alert political public, prefer to remain uninformed. Military officers, especially those who occupy posts at the highest echelons, are only dimly perceived as persons, decision-makers and political creatures. In the United States the military professions do not carry great prestige. However civilian political leaders are prepared to defer to the technical judgments of the military specialists and the public at large is uninhibited in acclaiming a few conspicuous and dramatic leaders as popular heroes.[7]

Significantly, civilian perceptions of the professional officer are not the same as perceptions of the military hero. In contrast to the public acclaim accorded individual heroes, officership remains a relatively low-status profession. The results of a national sampling of opinion in 1955 place the prestige of the officer in the armed services not only below that of the phy-

sician, scientist, college professor, and minister, but also below that of the public school teacher. Yet one of every two adult civilians stated that he would be pleased if his son pursued a career in the military services.[8]

Since the military has become more civilian oriented and the growth in size of the military establishment has increased, the organizational control over the individual soldier and officer has deteriorated. Family pressures serve to increase role conflicts. Military assignments involve constant rotation from one installation to another with each move, disruptions are created for the role of being a father does not necessarily coincide with being a professional soldier.

In the past, garrison life meant an intermingling of place of residence and place of work, especially during peace time. The military community had a strong sense of solidarity and offered extensive mutual assistance to its member families. While garrison life may have isolated the military from the civilian influences, it was a device for coping with the role conflicts and tensions that the military family had to face. But as the military becomes intermingled with the civilian, garrison life changes. The civilian community is not sensitized to the needs of the military families and to their special problems. Living in two worlds, the military family tends to compare its lot with that of the civilian neighbors, often resulting in a sense of dissatisfaction on the part of the military wife.[9]

The attraction of the military service for the professional involves such factors as style of life, social status, sense of mission and the importance of military honor. By sharp contrast, the negative image of the military establishment in American social structure stands as a powerful barrier to the recruitment of personnel. In a society in which individualism

and personal gain are paramount virtues, it is understandable that wide sectors of the civilian population view the military career as a weak choice, as an effort to "sell out cheaply" for the economic security and low pay and limited prestige.[10]

THE POTENTIAL FOR ROLE CONFLICT IN MILITARY OPTOMETRY

The Military Officer versus the Professional Officer-Optometrist

The military officer and the professional officer are two completely different life styles. The professional officer has a split identity. When you look at him you see a soldier, closer attention to detail will denote him to be an officer, a specialist in the Medical Service Corps. However, not until you question him will you learn that he is an optometrist. The optometrist who is in the military, by all of his training and by his affiliation with his professional organizations, in this case the American Optometric Association, the state association and usually district or local societies, identifies himself with the profession of optometry above all else. The optometrist in the Army is a part of the administrative corps, consisting of four sections: (1) Pharmacy, Supply and Administration, (2) Sanitary Engineering Section, (3) Medical Allied Sciences Section, consisting of such sciences as Bacteriology, Biochemistry, Parasitology, Clinical Psychology, Psychiatric Social Work, Medical Social Work, Podiatry, Entomology and Laboratory Technology, and (4) Optometry Section. The Optometry section is the largest professional group in the Medical Service Corps but only makes up to five to seven percent of the Corps. This is not to say that the largest number of specialists are the optometrists, only to say that they are the largest group of core health professionals in the Medical Service Corps. The transformation of the military establishment in size and in technology has had a profound impact on the social matrix of the officer and his career. First, the homogeneous, relatively intimate officer corps has been destroyed; the size and the heterogeneity of the corps has led to a more impersonal, complex, and bureaucratic military establishment. Second, the technological complexity of weapons and delivery

systems and the political involvements of the military have led to proliferation of professional skill requirements; the young officer must learn much more than military leadership. In the present military establishment, officers must often master skills which essentially train them for civilian as well as military occupations. Third, the relative isolation of the military from the civilian life has broken down; more civilians have experienced military life, more military personnel have been involved with civilian educational institutions and are presented with civilian career opportunities.[11]

The selection of a military career, like the selection of any career, represents the interplay of opportunity plus a complex of social and personality factors. In one sense, to say that the military is a mediocre career choice is an expression of a liberal ideology which holds that, since war is essentially destructive, the best minds are attracted to more positive endeavors. Commitment to a military career is much more closely tied to a feeling that one's skill is actually being utilized than it is to anything else.[12] The professional label is a mark of prestige, which then justifies exclusiveness of the group possessing the skill. Very little is indeed gained if levels of experience fall below those consistent with effective performance. The skill of the specialist who often functions outside the regular line of command, may continue to be in high demand by the military despite the fact that he fails to qualify for higher managerial responsibility. Hence personnel procedure can be modified so that he need not be subject to forced attention nor continuous rotation while the soldier officer needs new assignments to stimulate training and education.[13] The administrator must have progressively larger and more responsible assignments in a process of training. To the optometrist, patients are patients, regardless of where they are or under what conditions. Long term

assignments would not detract from his learning or preparation to one day assume control of his own clinic.

The military profession has always relied on and continued to emphasize non-monetary rewards - style of life, honor, group loyalty and public service as elements in building career commitments.[14]

When a member of one of the free professions becomes an employee of a bureaucratic organization, the organization often supersedes the ultimate control and authority normally invested in professional colleagues and the professional becomes a captive. The captivity of employment may then create conflicts for the professional caught between the value system of the profession and those of the organization which he submits.

The professional model of activity has always been that of the free agent contracting to perform a service for his client. However, this model gives little attention to the vast numbers of professionals who have always been employed by organizations and the changes which such employment brings about in the client-professional relationship.[15]

Professions which have a basic mandate to provide a personal service to an individual may find this mandate directly or indirectly challenged by the organizational priorities which require either practitioner or his client to place other considerations first.[16]

When the rewards are high enough, professionals may adapt their own professional ideas of competence, rewards and status to the value system of the organization they serve.[17]

Many times professionals readily abandon their own work for administrative duties so as to rise within the status hierarchy of the employing organization.[18]

Some intellectuals who are more professionally innovative may try to influence the existing bureaucratic system of priorities and values to conform to their professional definitions. The effectiveness of these attempts is open to question. Defeated or disillusioned, they often leave government service. Professionals who wish to succeed may well respond to the specific immediate pressures of their employing organization before the more abstract and distant expectations of their profession. Conflict resolution may be so successful that professionals may no longer perceive the existence of that conflict.[19]

One of the more significant features of the salaried professional is the fact that his work is subject to the evaluation and control of other individuals, who are not necessarily members of the professional group. These are managers whose authority governing the work of all employed derives from legitimatizing principals of bureaucratic administration.[20]

Normally when everyone agrees about the value (i.e., health) no problem arises. The problem of value orientation arises when the professional practitioner is employed to mediate between conflicting sets of values. The value of health, for example, may be in conflict with the need for available manpower.[21]

The Army has always been in the position of being a two different worlds or living two different lives. One of these is the Garrison life, maintenance, training and retraining, while the second is combat. These two different worlds are social and political and with this has been two different degrees of public attitude and support. A professional may be in complete accord with the method and technique of practice, patient care, professional support and style of life but may not remain associated with the military because of an inability to support the military purpose. The military was born, developed and maintained for destruction.

"I cannot remain associated with an organization that:

1. continually builds and prepares to destroy.

2. hopes for a "good war" to speed up promotions, growth and financing for development.

3. that primarily has its only growth, development and scientific gain during planning for or eliminating human life,"*

is a typical response from some professionals.

Research and Development for the Army Visual Services, recognizing that soldiers have garrison uniforms and combat uniforms, garison shoes and combat boots, has now proposed, garrison spectacles to go along with the combat spectacles. Also at the present time there is underdevelopment an "instant glasses" machine which will fabricate a complete pair of spectacles in less than ten minutes from raw materials.

The optometrist with a Doctors degree, a six-year educational program, is still a part of the Medical Service Corps, (Administrative Corps). He is the only specialist in the Medical Service Corps that is drafted under the Doctors Draft Law. The optometrist, drafted under this law is the only professional who does not receive professional pay in addition to his regular military pay and allowances as do physicians, dentists and veterinarians.

The current youth movement and general public dissatisfaction against the war has decreased the desirability of military service and the ease of procurement, particularly among professionals. The cornerstones of convention such as "God and Country", "My country, right or wrong, my country," "the competence of the government," "the wisdom of parents," in sum "the establishment" are no longer held with the respect that there were formerly.

*Unpublished correspondence.
Also Janowitz, Morris, The Professional Soldier: Professionals in Violence, pp. 3-16.

The professional in organizations is naturally different from others in the organization. The professional unlike his non-professional peers, deals with privileged communication. He is not in the business of transfering learning to his client. He has as his main concern, the "here and now" of the patients. The decisions made by the professional are not visably appealing to an "outside or higher" body.[22]

All subgroups of the society tend to develop their own ways of perceiving and conceptualizing the "facts" of their world, their own particular goals and scales of values, their own language, meaningful to them but "jargon" to the outsider and their own body of technology with which they operate on the objects of their special concerns. In the health field, for example, the medical practitioner is trained to see his problems in terms of the individual organism or segments of it; the social scientist conceptualizes his problems in terms of interaction among organisms. If the physician thinks of the environment, it is primarily the physical environment that he considers important. Attempts of the social scientist to analyze the process of social interaction, the development of roles and their systematic relations in institutional patterns and the relating of these facts to illness and health, are likely to strike the physician as lacking in reality and relevance. While the social scientist perceives the physician as deplorably narrow and naive about the dynamics of human relations, his own innocence of biological sophistication makes him appear to the latter as unsound or doubtful of competence. The structure of medical institutes is frequently more rigid and authoritarian than the somewhat more informal and much less authoritarian patterns of academic life in which the social scientist is trained. Sometimes the contrasting patterns in this respect are extreme as

in cases where the social scientist finds he is expected to clear all his papers with the medical officer of his institution or department and to list his superior as joint author, sometimes as senior author of all publications. Indeed, the whole way of life, from basic theoretical orientations to the irksome details such as whether or not to wear a white coat when on duty, presents the social scientist with the problem of assimilating a strange culture simply to achieve intelligible communication with the new associates. But the social scientist in the health fields may take some comfort from the knowledge that his colleagues who elect to work with other professionals confront problems of subcultural difference, more difficult to bridge than in the case of the health professions. Unfortunately, the participants of these cross cultural experiments too often interpret their differences and difficulties in personal terms. People are judged to be stupid, stubborn, self-defensive, whereas in reality they are acting as the products of their respective occupational subcultures of professional prejudice.[23] These optometrists might take this fact that this is universal feelings in interprofessional relationships, especially in large bureaucratic organizations.

A BRIEF HISTORY OF MILITARY OPTOMETRY

Optometry is relatively new to the military, as its function began mainly from World War II through the Korean conflict to the cold war of this time, and more recently to the conflict in Southeast Asia. The primary role of optometry as a part of the Medical Service Corps, is the improvement of the vision care offered to the American soldier.

During World War II Optometry's role was an informal one. Optometrists were drafted as basic soldiers without recognition of their training or professional status. Fortunately, classification and assignment policies channeled many of them into the medical service. The critical need for vision care led to the utilization of their special training and skills, although they were never identified by any specific Military Occupational Specialty (MOS). This state of affairs created a natural resentment of their low status. They felt they should be formally recognized as a profession and be given commissioned status along with the other health care groups. The American Optometric Association accepted the cause and their efforts resulted in the passage by both houses of Congress 1946, a bill establishing an Optometry Corps in the Army. President Truman vetoed the bill because of an impending reorganization of the Army Medical Department which would include Optometrists as commissioned officers.

Public Law Number 337, passed by the 80th Congress in 1947, established the Medical Service Corps as a part of the medical service of the Army and Navy. This law in effect, created a corps of commissioned officers in the two services composed of people specializing in administration and in scientific and professional fields allied to medicine. Under this law, optometry was set up as a section within the structure of the Medical Service Corps of both services.

This was the first congressional legislation that made it possible for optometrists to be commissioned specifically on the basis of training and education.

Between the years of 1947 and 1955 many things were to occur. Primarily, optometrists were drafted and utilized in clinics, working along side of commissioned optometrists and with a ceiling on the number of commissioned Medical Service Corps Officers and the vast requirement for visual care, commanders felt justified in using these enlisted optometrists, because they were trained, properly licensed and available to fill the need. During the first session of the 84th Congress, a conference was held in the House of Representatives on the 1955 amendments to the Universal Military Training and Service Act and the extension of the Doctor's Draft Act (Report Number 902) coming out of the committee headed by U. S. Representative Carl Vinson and had this to say about Optometry:

> The managers of the House and Senate discussed the situation with regard to optometrists. Both the House and Senate managers are conscious of the fact that the Department of the Army is using optomotrists in their professional capacity as enlisted men. It is the opinion of both House and Senate managers that the Armed Services, should, if they utilize optometrists in their professional capacities, offer such individuals commissions. In other words, if an optometrist, he should be offered a commission commensurate with his professional attainment.

In April, 1956, the Secretary of the Army established a ratio of approximately one optometrist (commissioned) per 7,500 troop strength. This was the first time that a definite yard stick for the determination of optometry officer spaces had been applied since the Army Medical Service Corps came into being in 1947. Based on the troop strength of the Army for 30 June 1956, this meant that 137 commissioned optometrists would be required.

A massive recruiting program was instigated to fill these slots. This was fairly successful but by the end of Fiscal Year 1957 the authorization had

been raised to 148 slots. By mid April the actual number of optometrists was down to 125 and medical commanders began complaining to the Surgeon General that these shortages were creating excessive patient backlogs. The Chief of the Optometry section went on a personal recruiting program. The State Optometric Associations and the American Optometric Association also assisted and although the task was far from easy, it was a success.

The strength of the Army went up following the Berlin crisis in 1961 and by July 1962 the optometry authorization was up to 178 spaces. At this time the shortage of Optometrists was 31. During World War II and Korea, there were sufficient available optometrists and not enough slots in the military but now in 1963 there were sufficient slots but not enough graduates to fill them. During the Fiscal Year 1965, the authorization went up to an all time high of 186 spaces. The Surgeon General increased the authorization from one optometrist per 7,500 troops to one per 5,000 troop strength. A survey to determine true need was done early in 1965 and this showed a need for optometrists in excess of three hundred. Previous experience showed that recruiting efforts would never be capable of filling the demand.

Department of the Army requested that the existing provision for the inclusion of optometrists in the Doctors Draft Act be implemented and that the Selective Service System provide the Army with 100 optometrists. Concurrent with this was an administrative decision that optometrists would be given an entry rank of First Lieutenant. The Selective Service System set their machinery in motion, quotas were allocated to the State Systems and in turn the local Draft Boards began to select their friends and neighbors for service in the Army beginning in July 1966. The resultant publicity resulted in a flood of volunteer applications to the Office of the Surgeon General from

young optometrists eager to get their service over. This rapid transition from famine to feast provided about 200 optometrists, almost 50 in excess of requirements but in an amazingly short time all were provided with equipment and put to work.

The increased entry rank of first lieutenant was widely acclaimed in Army Optometry circles and was more than welcome. Starting at second lieutenant while other professions started at Captain had been a sore point for many years. The increase in the educational requirement from five to six years was also taking place at that time had accentuated the problem. The problem was recognized by the Office of the Surgeon General and D.A. Cir. 629-39, 15 August 1967 set forth criteria for promotion and entry grade of certain Medical Service Corps specialists based on credit for education beyond the baccalaureate degree. Optometrists were given 24 months credit as graduates of a six year educational program. Present promotion criteria provides an entry rank of Captain when combined with the service credit granted in this circular. This then made the entry rank comparable with that of the other health professions. (Recently the Army has announced that the promotion time from second lieutenant to Captain will be increased to 42 months. The July 1971 entry class of optometrists will be the last of the entry as Captains and that all following will enter as first lieutenants with a variable promotion time to Captain. This naturally has brought forth a cry of discrimination.)

The year of 1967 brought forth another change in the Army optometric picture, considered to be of great importance. History may or may not reveal its true impact. Optometry in the Army, was born in a time of peace and the utilization of optometrists developed along lines suitable for that condition. Vision care was geared for a garrison type army and no provisions were made

for the care of the field soldier under combat conditions. The infantry man who is dependent upon spectacles for combat effectiveness becomes a casualty and a logistic burden when he loses or breaks his glasses. Too often he must be evacuated to a rear area for examination and must remain there until the required correction is obtained. Even though his prescription is available, it still required a week or two to provide the spectacles. In combat, 100 percent effectiveness is a luxury that few commanders ever have and to have men ineffective for the lack of spectacles was unreasonable. The solution to this problem was at long last provided in DA MSG 840514, 20 November 1967 changing the Table of Organization and Equipment of all Divisions to include an optometry section consisting of two optometrists and two opticians and the equipment necessary to provide for examination and the fabrication of single vision spectacles within the Division area. The service these sections render and the resultant saving in combat effectiveness has been most enthusiastically received.[24]

The strength of the optometry section in the Army today is set at 286 and it has been so difficult to obtain a sufficient number of optometrists to meet this need that there have been three special Selective Service calls for optometrists this fiscal year while at the same time, the Selective Service calls for dentists has been cancelled, because of sufficient volunteers to meet the quota.

THE METHOD OF STUDY

THE METHOD OF STUDY

This study is the result of a questionnaire sent to 341 optometrists who have completed at least two years of active duty with the Army, honorably separated and are now in a civilian practice of optometry. The location of these men was determined through a catalog system of military optometrists maintained by the author at Fort Sam Houston, Texas. The current addresses were obtained from the American Optometric Association, St. Louis, Missouri and the Blue Book of Optometrists, The Professional Press, Chicago, Illinois.

The questionnaire was designed by the author from his experience with Military Optometry and Optometrists with the assistance of Dr. Edmund M. Ricci, Assistant Research Professor of Sociology, Department of Public Health Practice, Graduate School of Public Health, University of Pittsburgh. This project for a Masters Thesis was first suggested by Mr. H.E. "Tony" Mahlman, Executive Director of the American Optometric Association, Washington Office, who is the representative of the American Optometric Association to the Congress of the United States.

The intent of the questionnaire was to determine the attitude of these optometrists towards the Army, Optometry as practiced in the Army, the factors which contributed to their leaving the Army and what they consider to be the important factors that would have induced them to remain in the Army or to return to active duty.

The response was overwhelming. Of the 341 questionnaires mailed out, 25 were returned by the post office for various reasons, primarily insufficient or incorrect addresses. Of the remaining 316, 33 percent were returned, completed within ten days, 40 percent were returned in thirteen days and 51 percent by the fourteenth day. An additional 14 percent were received the following ten days for a total of 65 percent in less than 30 days with a total

return of 69.3 percent. This is a highly satisfactory rate and quantity of return. Most surveys of this type are fortunate to get 65 percent after several months and numerous follow-up letters. Two of the returned questionnaires were not usable, one being incomplete and one completed by an optometrist not in the control group who had World War II military service, not as an optometrist. (right name, wrong person) In addition to the questionnaires, 17 letters and notes were received with additional information, comments, suggestions and offers of assistance. Twenty percent of the questionnaires contained additional information and comments. These additional replies were well thought out comments, analysis, work reports, patient data and particular working conditions or situations. Only one of these additional comments was sarcastic with intent to ridicule.

It was felt by this writer and his advisors that such a high and rapid rate of return indicated a sincere interest in the problem and while a follow-up could have easily increased the percent of return, those that answered only following pressure or pleading might influence the statistical analysis of the serious work submitted in the early returns. As a matter of record, it was noted by this writer that the later returning questionnaires contained less additional information than those returned the first two weeks.

Therefore, the results of this study are from one mail out, with no additional follow-up and is considered highly representative of those surveyed who have a deep concern for the future of military optometry.

PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

A. Description of Personal Characteristics of the Respondents

The respondents to this questionnaire are a group of young men who have eached served in the United States Army recently and honorably completed their military obligation. They entered the Army subsequent to the first use of the Doctor's Draft Law to secure optometrists. (1966)

This survey incorporates the opinions of Junior Officers and Optometrists, with a combined total experience in excess of 450 man years. The responses were freely given and no pressure was attempted to have the questionnaires returned. The opinions expressed are a composite of how they observed the Army and Military Optometry--its assets, liabilities and shortcomings.

The initial mailing of questionnaires was 18 March 1971, and as explained the response was rapid. The number of questionnaires returned totaled 219, of which 215 were usable, two were received following final tabulations, and two were incomplete.

Although all these men separated from the Army as Captains, their entry rank varied according to the date of entry into active duty. All were commissioned but entered the Army at different ranks, depending upon the time in grade for promotion experienced by the Army at the time.

Table 2
Entry Rank of Optometrists Surveyed

Rank	N	%
Captain	73	34.4
First Lieutenant	111	51.2
Second Lieutenant	31	14.4
Total	215	100.0%

About one half of these officers had been in some type of practice prior to military service (50.2%) and the other half came directly from college.

Table 3
Optometric Experience Prior to Military Service

Type of Practice	N	%
None	107	49.8
Solo practice	13	6.0
Associate practice	20	9.3
Group practice (3 or more optometrists)	6	2.8
Group practice (multi-discipline)	3	1.4
Employed by an Optometrist	40	18.6
Employed by an Ophthalmologist	9	4.2
Employed by a firm	4	1.9
Other	13	6.0
Totals	215	100.0%

They have all served a minimum of two years, some served longer to secure an overseas tour. Of the varied assignments, 69.3 percent did not have service outside the continental United States and 7.8 percent did not serve in the United States, with 22.9 percent having service both overseas and stateside.

Stateside service was divided fairly evenly among the 4th, 5th and 6th Armies, with a higher percentage in the 1st and 3rd Army areas due to the heavier concentration of basic and advanced training centers which have larger clinics.

Table 4
Distribution of Optometrists Surveyed
Continental United States

Army Area	N	%
First Army	53	27.7
Third Army	47	24.5
Fourth Army	35	18.3
Fifth Army	29	15.1
Sixth Army	27	14.1
Totals	191	100%

The clinics in the First and Third Army areas were also used as a manpower pool since withdrawal of one man from a large clinic would cause less hardship than it would have caused in one with less staff.

Of the respondents, 12.5 percent served in Viet Nam, in addition to stateside service.

Table 5
Army Areas Assigned Outside the Continental United States

Army Area	N	%	% (of total
Viet Nam	26	54.0	12.5
Korea	3	6.2	
Europe	14	29.0	6.7
Alaska	1	2.0	
Hawaii	2	4.1	
South America	2	4.1	

Of the respondents, only one was from a military family, 26 were from an Optometric family.

The respondents are all involved in optometry now, 5 percent are teaching or in research in Optometry schools and the remainder are in direct patient care.

Table 6
Type of Professional Practice Following Army Service

Practice Category	N	%
Solo Practice	85	39.9
Associate Practice	75	35.2
Group Practice (Three or more Optometrists)	16	7.9
Group Practice (Multi-discipline)	6	2.8
Employed by an Optometrist	10	4.6
Employed by an Ophthalmologist	5	2.3
Employed by a firm	5	2.3
Other	11	5.0
Total	213	100.0%

Non-solo practice as experienced in the Army seems to have made a lasting effect as evidenced by the quantity of group practices in which they now practice.

The amount of time the respondents spend in their offices in actual practice of optometry ranges from 30 to 60 hours per week, with the highest percentage working 38 to 42 hours per week.

Table 7
Hours of Office Time Per Week

Hours worked per week	N	%
30 to 33	22	10.4
34 to 37	40	18.9
38 to 42	76	36.0
43 to 46	28	13.3
47 to 50	31	14.7
51 to 54	4	1.9
55 to 58	1	0.5
59 plus	9	4.3
Total	211	100.0%

At the time of separation from the service, the majority were married and this must be considered a factor in a military career as the Army is a total family career.

Table 8
Marital Status at Time of Military Separation

Category	N	%
Married	174	81.3
Single	39	18.2
Divorced	1	0.5
Total	214	100.0%

All respondents were separated from the Army during the years 1968 through 1970. Of these 54.5 percent were separated in 1968, 11.1 percent in the year 1969 and 34.4 percent in 1970. Therefore, the majority of these optometrists have had as much as two and one-half years of private practice in which to make a comparison between military optometry and civilian optometry which they had practiced in the city of their choice. The views are therefore valid in determining the level of satisfaction in professional practice.

The most difficult determination was income and income range. It was finally decided the only way to produce any factual information would be to divide respondents into year groups by date of separation.

Table 9
Income 1970 for Respondents Separated in 1968, 1969, 1970

Income	1968 N	1968 %	1969 N	1969 %	1970 N	1970 %
Less than $3,000	1	0.7	1	4.3	1	1.3
$ 3,000 - 4,999	2	1.4	3	13.0	5	6.5
5,000 - 7,499	4	2.9	0	- - -	11	14.7
7,500 - 9,999	15	11.0	2	8.7	23	30.0
10,000 - 12,499	23	16.9	5	21.7	24	31.1
13,000 - 14,499	14	10.2	3	13.0	5	6.5
15,000 - 17,499	14	10.2	3	13.0	5	6.5
17,500 - 19,000	10	7.3	0	- - -	1	1.3
20,000 or more	30	22.0	6	26.0	2	2.6
Totals	112	100.0%	23	100.0%	77	100.0%

We can see a much more even distribution of those separated in 1968 with fewer in the lower brackets. Respondents separated in 1969 show a higher percentage in low income during 1970 due to no income other than civilian practice. Location of practice also causes a variance in income.

Table 10
Distribution of Respondents by College of Optometry

Name of College or University	N	%
Illinois College of Optometry	31	14.4*
Indiana University Division of Optometry	13	6.0
The Los Angeles College of Optometry	16	7.4
Massachusetts College of Optometry	11	5.1
Ohio State University College of Optometry	15	7.0
Pacific University College of Optometry	30	14.0*
Pennsylvania College of Optometry	40	18.6*
Southern College of Optometry	32	14.9*
University of California School of Optometry	10	4.6
University of Houston College of Optometry	17	7.9
Total	215	100.0%

*There is no clearcut pattern shown by colleges, because Optometrists are drafted by States. From the percentages in Table 10, there is some indication that some schools seem to create more of a desire in their students to serve in the military.

B. Attitudes About Aspects of Military Life Not Related to the Practice of Optometry.

The respondents, having been assigned all over the world, some with service both overseas and stateside, have had a good look at Army life. In response to the point of feeling a part of the military family, 62 percent felt that they were part of the family.

Table 11
Did you feel you were a part of the Military Family?

Response	N	%
Yes	134	63.5
No	77	36.5
Total	211	100.0%

Table 12
Did you have post housing?

Response	N	%
Yes	121	57.9
No	88	42.1
Total	209	100.0%

From this we find that 82 (61.2%) of those who felt they were part of the military family had post housing. This might indicate that to establish a feeling of belonging to the organization, post housing is an integral part of this feeling and that a renewed effort should be made in the provision of post housing, its improvement and maintenance.

Fifty-one percent of the respondents felt there was pressure applied on them to belong to the Officers' Club and several stated there was no choice, club membership was automatic. Another 30 percent felt that there was some pressure applied to join the Club, but that it was not excessive. Only seven respondents did not belong to the Club. Participation in Club activities, 62.9 percent reported they went to the Club only occasionally, 6.3 percent stated they never went to the Club although they were members.

Table 13
Members of The Officers' Club

Response	N	%
Yes	208	96.7
No	7	3.3
Total	215	100.0%

Table 14
Participation in Activities of Club

Response	N	%
Frequent	64	30.8
Occasional	131	62.9
Never	13	6.3
	208	100.0%

Several respondents stated that it always seemed that the Officer Clubs catered to the "singles" and the Senior Officers and the Retired members with little real "draw" to the young married with children. Several respondents stated they could not afford to attend the Club, pay a babysitter, other than command performances and special occasions. The prices in the Clubs were not an inducement when civilian clubs were comparable and sometimes less expensive.

The post facilities for recreation and hobbies were found by the majority of respondents to range from good to excellent and had enough recreation time to utilize them.

Table 15
Quality of Post Facilities for Hobbies and Recreation

Response	N	%
Excellent	67	31.1
Good	103	47.9
Fair	35	16.3
Poor	7	3.3
Don't know	3	1.4
Total	218	100.0%

The commissary and post exchange came under considerable criticism, particularly for the condition of the facilities, overcrowding and limited selection. There was high utilization of each of these facilities, however 66.8 percent stated that the exchange was only of some value (saving money on basic items), while 26.1 percent considered it of high value. The commissary fared much better with 47.9 percent stating it was of high value. Approximately 6.5 percent stated they usually shopped elsewhere.

Table 16
Unfavorable Comments Regarding PX

Response	N	%
Too crowded	40	18.8
Too expensive	9	4.2
Poor quality	8	3.7
Limited selection	95	44.1
Poor facilities	6	2.7
Indifferent sales personnel	15	6.9
Insufficient checkout lines	11	5.5
Lack of latest fashions	6	2.7
Other*	25	11.6
Total	215	100.0%

*Other includes a range of complaints from all of the above, a combination of the above, and no complaints.

Crowded PX's and Commissaries are a fact of military life now, and to this writer's knowledge, always have been. The military once-a-month pay system has greatly contributed to this pattern of "get what you need to last the month while you have money" feeling. The complaint of poor facilities in the PX's is possibly a bit harsh as most main PX's are modern, well equipped facilities. How they are stocked is usually in relation to the date of the month. The new Army twice-a-month pay system (effective August 1971) should have a great effect in this nature. Basic training centers seem to have the greatest incidence of "empty shelves" for a week following pay day than do more stabilized population posts.

In summary, the criticism against "THE ARMY" as determined from this survey, is that it is too big, too impersonal, and the plans for the operation

of anything in the Army is to do what is best for the majority of its personnel.

C. The Army and the Profession of Optometry

The results of this study while quite fair to "The Army" in general, suddenly took a sharp turn when it came to the profession of Optometry and the autonomy of the professional optometrist. Many things could have been improved. The building, the equipment, the eye wear, even the quality of care. Professional standards, personal ethics, and "that is not the way we did it in school" was an uphill battle all the way. "If I had been given more time, more equipment, fewer patients, more freedom, etc. I could have created Utopia." This might or might not be true - the author does not feel qualified to make that analysis.

The professional man in any field who is satisfied with status quo is in the wrong profession, or certainly the wrong place. Optometry, or any profession, in or out of the military, must continually seek to improve itself. The cry today is "If you are not part of the solution, then you are part of the problem" and this is certainly true. The military spectacle came under considerable criticism and part of this is true, but all military optometrists cannot be in research and development, researching and testing for a new frame. In an organization of this size, there are those who spend full time with these problems. Equipment received the highest praise in any category about the optometry facilities, with 41 percent considering it excellent and 36 percent considering it good. Good equipment is a savings in repair, maintenance and time, and therefore economical even though the original cost is sometimes higher.

The military optical facilities, fabrication of spectacles were considered excellent by 11 percent of the respondents, 44 percent rated them good,

Table 17

CONDITIONS OF MILITARY OPTOMETRY

	N	%	N	%	N	%	N	%	N	%	Totals	
	excellent		good		fair		poor		very poor			
Your Optometry Clinic (the building, fixtures, maintenance, efficiency, etc.)	34	15.8	82	39.1	53	24.6	31	14.4	15	6.9	215	100%
The Optometric equipment provided for your use	89	41.5	75	35.0	40	18.6	6	2.8	4	1.8	214	100%
The standard military frame	9	4.2	79	37.0	90	42.2	24	11.2	11	5.1	213	100%
The quality of military lenses	35	16.2	124	57.6	42	19.5	12	5.5	2	0.9	215	100%
Quality of military optical laboratory services	23	10.8	93	43.8	72	33.5	15	7.0	9	4.4	212	100%
Quality of the PX optical concession	13	6.0	49	22.9	75	34.6	37	17.3	30	14.0	204	100%
Patient attitude toward Optometry	54	25.3	134	63.5	24	11.2	1	0.4	0	--	213	100%
The quality of Optometric care provided in your clinic	57	26.5	105	48.8	46	21.4	7	3.2	0	--	215	100%
Your usual duty hours	49	22.7	134	62.3	26	12.0	5	2.3	1	0.4	215	100%
The rapport you were able to reach with your patients	59	27.4	106	49.3	44	20.4	6	2.8	0	--	215	100%

33 percent considered them to be fair, while only 12 percent thought of them as poor. The primary criticism was of the single vision optical laboratories which are not under control of optometrists as are the large laboratories in Fitzsimons General Hospital, Einsidlerhof, Germany; Okinawa and Cam Rahn Bay, Vietnam. The single vision labs are managed by non-commissioned officers, under the direct control of Supply and Services Division. It was felt that there should be more of these labs but that they should be under the direct control of optometrists. The PX Optical concessions were another story, with only 6 percent of respondents considering them excellent, 24 percent considered them good. The prime concern was that these were set up to provide quality spectacles to the GI and his dependents, but the prime consideration of who received the contract for the concession was who would give the PX the biggest percentage, not who would provide the best service and price to the military customers. Although most optometrists (73 percent) thought that better visual care could have been provided, 26 percent were of the opinion that the care given was excellent, an additional 49 percent considered the care good. Only a small minority of seven individuals considered the care poor, but there were none who thought it very poor. Patient attitude toward optometry was considered good. Many people entering the Army have never been examined by an optometrist, some of them wonder what you do, so a selling job is frequently undertaken. Twenty-five percent of the respondents felt that patients had an excellent attitude toward optometry, while 62 percent felt that the patient attitude was good. Most professions seem to progress in the civilian community as they progress first in the military services. Optometry being a young profession, faces the problems of acceptance as a profession.

The position occupied by the Optometrists, in the organized system of military medicine, was in (1) Optometry Clinics, (2) Ophthalmology Clinics, and (3) EENT Clinics. The clinic size (only considering optometrists) ranged from one to fourteen with the highest percent of clinics having 4 or 5 optometrists, with only 13 percent practicing in clinics having more than 9 optometrists, which is the same number that practiced alone, 23 percent practicing in small groups, two to three optometrists, and 51 percent practicing in large groups, four to nine optometrists.

Table 18
Size of Clinics

Number of Optometrists	N	%
1	28	13.0
2	34	15.9
3	15	7.0
4 or 5	44	20.5
6 or 7	33	15.4
8 or 9	33	15.4
10 or 11	10	4.6
12 or more	17	7.9
Total	214	100.0%

The supervisors in these clinics were generally optometrists, 74 percent followed by ophthalmologists and other physicians.

Table 19
Immediate Supervisors

Category	N	%
Optometrists	157	74.0
Ophthalmologists	21	10.0
Otolaryngologists	4	2.0
Other Physicians	31	14.0
Administrators	2	0.9
Total	215	100.0%

The patient load varied from twelve or less to over twenty per day. This is again a difficult total to give accurately. A "patient" or a "physical" or a "limited examination" means different things to different people. Those assigned to the large training centers were inclined to give much higher numbers of patients seen, due to the trainee population examinations.

Table 20
Number of Patients Seen Per Day, Per Optometrist

Patients	N	%
12 or less	44	20.8
13 - 14	34	16.1
15 - 16	70	33.1
17 - 18	14	6.6
19 - 20	2	0.9
more than 20	47	22.2
Total	211	100. %

There has been a discussion going on in Military Optometry for several years as to what constitutes a patient. We still have not reached a satisfactory agreement. The preferred term to denote a patient is a visual analysis or visual examination. This refers to the complete examination, internal examination, external examination, case history, visual acuity, determination of refractive status and functional status of the eyes, determination if a prescription is needed and writing the prescription. The military patient does not always fit this nice neat mold. In the military there are physicals in addition to routine visual analysis: (1) induction, (2) separation, (3) flight, (4) academy, (5) airborne, (6) ranger, (7) special forces, (8) drivers license, (9) re-enlistment,(10) annuals, and others, all of which take time. Most of

these physicals require a refraction, which is part of a visual examination for completion. False yardsticks of work in a bureaucracy bring on discontent. This leads to consideration of the figures given. An Optometrist who provides in excess of twenty full visual examinations per day for two years, is either extremely fast and extremely good, or he is burned out for years to come. Numbers are vastly too important in a bureaucracy and Table 20 shows a wide discrepancy in output. Somehow, there must be developed a better system of accounting. The post clinic in the non-basic training center will show much less of a ratio per optometrist as most examinations will be complete examinations. The popular retirement post areas such as Fort George G. Meade, Maryland; Fort Sam Houston, Texas; Fitzsimons General Hospital, Denver, Colorado; Madigan Army Hospital, Seattle, Washington; Walter Reed General Hospital, Washington, D. C. to mention only a few that are extremely popular retirement areas, will have a high population of older patients which are extremely time consuming.

The clinics themselves were considered from the point of condition of the building, fixtures, professional equipment, maintenance and working efficiency. Of those responding, 66.1 percent considered the clinics good to excellent while only 12.5 percent considered their clinic poor to very poor. An exact breakdown is as follows:

Table 21
Condition of Military Optometry Clinics

Buildings, etc.	N	%	Equipment	N	%
Excellent	34	15.8	Excellent	89	41.6
Good	83	38.2	Good	75	35.2
Fair	53	24.7	Fair	40	18.6
Poor	31	14.4	Poor	6	2.8
Very poor	15	6.9	Very poor	4	1.8
Total	215	100. %	Total	214	100. %

Table 22

Quality of Military Optical Support					Civilian Optical Support (PX)	
	Frame		Lenses			
Condition	N	%	N	%	N	%
Excellent	9	4.2	35	16.2	13	6.4
Good	79	37.0	124	57.6	49	24.0
Fair	90	42.2	42	19.5	75	36.7
Poor	24	11.2	12	5.5	37	18.2
Very poor	11	5.1	2	.9	30	14.7
Total	213	100.%	215	100. %	204	100. %

We can see from this breakdown that the military lenses were much more highly thought of than the military frame. The military frame is manufactured on a specification bid while the lenses are stock manufactured for the world market. Considering the frames, any time you have "lowest bid" material, some barely meet the minimum standards while some exceed the minimum greatly. One particular company was highly criticized for the frames breaking, discoloring, and poor workmanship. Considering lenses, the military standardized the straight top 25 mm bifocal and put it into general use, thereby driving down the price on the civilian market by causing development and expanded facilities and as a result has provided a better lens to be available for the public consumption, and at a better price.

The military facilities and their optical work was much more highly thought of than was the civilian PX concessions.

In the practice of optometry in the Army, 53 percent felt they were given the opportunity (always and usually) to be original, to exercise leadership and to be free from pressure to conform in their professional standards. In utilization of their professional education, 15 percent of the respondents felt that they were never allowed to utilize their education to the fullest; 34 percent felt the utilization was usually possible but only 12 percent felt that they always had this opportunity. Eighty percent had the opportunity to work closely with other optometrists and 56 percent liked this group practice very much. They also had the opportunity to work, in varying degrees, with other professionals, (only 7 percent did not) and were generally pleased with the relationship from the point of cooperation and assistance received, however some were disappointed with the relationship as a learning experience with 31 percent very dissatisfied. This experience has had a lasting effect upon these respondents since 55 percent are in a group practice of some type.

Table 23
Attitude Toward Military Practice of Optometry

	Always		Usually		Occasionally		Never	
	N	%	N	%	N	%	N	%
Have the opportunity to be original	27	12.5	78	36.2	94	43.7	16	7.4
Have a chance to exercise leadership	20	9.8	81	39.7	93	43.2	21	9.7
Have the opportunity to experiment with various techniques/methods	22	10.2	65	30.2	106	49.3	22	10.2
Have the opportunity to work closely with other disciplines	51	23.7	64	29.7	81	37.6	18	8.3
Have the opportunity to work closely with other optometrists	112	52.0	61	28.3	22	10.2	19	8.8
Have freedom from pressure to conform in professional standards	40	18.6	109	50.6	48	22.2	11	5.1
Have social standing and prestige among other groups	50	24.5	112	52.0	45	20.9	6	2.7
Have the opportunity to use your education to the fullest	25	11.6	72	33.4	83	39.6	32	14.8

The next higher supervisor of the respondents changed drastically in proportion from the immediate supervisors. While the majority had optometrists for immediate supervisors, 56 percent reported that they had ophthalmologists as second in their cnain of command. Two individuals reported that in the division units they had administrators for the second higher supervisor and these individuals felt that administration was more important than patient care. One reported that as a division optometrist he had only administrators as supervisors and that this was highly unsatisfactory due to the lack of mutual understanding of patient care. These are isolated instances but show that in spite of interprofessional problems, the problems of working for someone who is not professionally in direct patient care is even worse.

In direct patient care, 23 percent stated that they never had to perform limited 'quickie' examinations, however 9 percent stated that they always had to use the limited or 'quickie' technique. The remaining 68 percent stated that they had to occasionally or often resort to this technique, however it was usually related to basic trainees who came to the clinic and had to be seen in a limited amount of time during in-processing and for various reasons could not perform all the finer points of visual analysis that they desired. Most were restricted from a contact lens practice and almost none practiced visual training.

It has been postulated that speed has only a limited effect on quality and this gains some credibility from the response to the question, "Did you have time to perform a good visual examination?" with only 2 percent stating that they never had sufficient time to perform a good visual examination and 35 percent stated they always had time for a good visual examination.

Table 24
Respondents who performed limited or 'quickie' examinations

Category	N	%
Always	20	9.0
Often	76	36.0
Occasionally	69	32.0
Never	49	23.0
Total	214	100.0%

Table 25
Respondents who felt they performed good examinations

Category	N	%
Always	75	35.0
Often	84	40.0
Occasionally	48	23.0
Never	5	2.0
Total	212	100.0%

Considering the professional value of their military experience, 16.0 percent of respondents claimed it was of little value and 17.7 percent claimed that military service actually hindered their professional career, however 39.0 percent felt that their service was of great value to them professionally and 16.7 percent have considered returning to the military.

Most respondents were satisfied with optometry as practiced in the military but resented what they considered low remuneration for the service rendered the military, especially considering the training and education.

The most important professional practice problems considered in making a decision to leave the army were:

Military patients become repetitious and offered no challenge ... 58%
Restrictions in scope of practice 56%
Having an ophthalmologist as a supervisor 45%
Not having time to do a complete examination 42%
Inability to follow a patient after the initial examination 41%
The feeling that they had to assume responsibility for an excessive number of patients 36%

See Table 26 on Page 49.

Non-optometric duties are a sore spot with many optometrists, especially those from the larger clinics. Only 8.3 percent of respondents reported that they never had additional duties while 15.8 percent said this duty was frequent.

Table 27
Frequency of Non-Optometric Administrative Duties

Category	N	%
Frequent	34	15.8
Occasional	96	44.6
Seldom	79	36.7
Never	18	8.3
Total	215	100. %

The above table does not include AOD (Administrative Officer of the Day). It was amazing to see that 23.7 percent of the respondents thought that optometrists should perform the duty of AOD. (AOD is duty as the hospital administrator, registrar, treasurer, etc., during the hours after normal work time, usually 4:00 P.M. until 8:00 A.M. the following morning. Usually a sleeping room and office are provided for use of the AOD, if he has the time. (Compensatory time off the following day is by local policy.) Most of the respondents felt that they were not qualified to assume this responsibility.

Table 26

PROBLEMS IN MILITARY PRACTICE OF OPTOMETRY
N = 215 % = 100

	N	%	N	%	N	%	N	%
	A very serious problem		A fairly serious problem		A problem but not serious		Not a problem	
The number of patients for which you had to assume responsibility	29	13.4	49	22.7	76	35.3	61	28.3
Restrictions on the scope of your practice	57	23.7	41	28.3	59	27.4	38	17.7
Having ophthalmologists as supervisors	55	25.5	41	19.0	55	25.5	60	27.8
The inability to follow a patient following your initial examination	32	14.8	55	25.5	79	36.7	49	22.7
Even though you possessed the health record, being unable to find the previous Rx.	16	7.4	28	13.0	101	46.9	70	32.5
Utilization of screening techniques in lieu of a full visual examination	16	7.4	44	20.4	80	37.2	74	34.4
Military patients become repetitious and offer no challenge	110	51.1	36	16.7	81	37.6	87	40.4
Not being able to see children under age 6 or 7	30	13.9	37	17.2	39	18.1	106	49.3
You did not have the equipment to do what you considered best for the patient	24	11.1	35	16.2	48	22.3	108	50.2
Not having time to do an adequate or complete visual examination	43	20.0	46	21.3	63	29.3	63	29.3
Paperwork, spending a large amount of time not requiring your optometric skills	16	7.4	26	12.0	68	31.6	105	48.8
The fact that you had to wear a uniform during patient care	1	0.4	7	3.4	31	14.4	176	81.8

The respondents remembered the things about military life and practice that they liked, particularly camaraderie, 38%; a chance to travel, 45%; group practice, 56%; professional experiences, 45%; and 58% paid vacations and holidays.

Table 28
Characteristics of Military Life and Professional Life

	Liked very much		Liked somewhat		Of no importance		Disliked	
	N	%	N	%	N	%	N	%
Camaraderie	76	38.0	70	34.0	47	23.0	4	2.0
Chance to travel	97	45.0	73	34.0	34	16.0	9	4.0
Group practice	118	56.0	70	34.0	19	9.0	2	1.0
Regular working hours	111	52.0	71	33.0	21	10.0	10	5.0
Professional experiences	95	45.0	93	43.0	19	9.0	5	2.0
Security	78	36.0	64	30.0	62	29.0	10	5.0
Post graduate education	48	21.0	82	39.0	60	30.0	22	10.0
No financial investment	76	36.0	59	27.0	76	36.0	3	1.0
Guaranteed income	75	35.0	83	39.0	47	22.0	9	4.0
Retirement benefits	87	41.0	66	30.0	53	25.0	8	4.0
Second career while young	60	29.0	62	29.0	85	40.0	7	2.0
Paid vacation and holidays	125	58.0	67	31.0	21	10.0	1	*
Social and cultural activities	44	21.0	103	48.0	45	21.0	21	10.0

* less than 1%

From the preceding Table 28, we can see that there were many things about the military that were liked very much. Only two things stand out which were disliked or of no importance. Most of these young men had just finished six years of college prior to entry into the Army and ten percent did not want more education and 30 percent stated that post-graduate education was of no importance. I think this can be summed up simply as having had enough school for now and not seeing the long range need for more education. "Let's get the heck out of school and make some money." A second career while at a young age was not determined to be advantageous, particularly if you desire to start a new practice. Not having a financial investment was not deemed important and I think this was seen as if they had bought the equipment, they would have done much better or to their taste.

The respondents were asked to evaluate the military service on their professional knowledge and capability. Each of them, in all probability, had seen more patients during their military career than they would have seen in a private practice during the same period of time. They were expected to see a great many types of patients, considerable amounts of pathology, and to be able to develop their own techniques during this time. Their knowledge should have increased greatly during this time. Only 16 percent of the respondents felt that the experience was only of little value. Eighteen percent felt that the military services actually hindered their career.

Table 29
Value of Military Service Professionally

	N	%
Great value	83	39.0
Some value	96	45.0
Little value	34	16.0
Total	213	100.0%

Table 30

ATTITUDES TOWARD MILITARY PRACTICE

	N	%	N	%	N	%	N	%	Totals	
	Well satisfied		Somewhat satisfied		Mildly dissatisfied		Very dissatisfied			
The opportunity to provide high quality visual care to your patients	65	30.2	81	39.6	44	20.4	25	11.6	215	100%
The opportunity to maintain a good doctor-patient relationship	75	34.8	78	36.2	53	24.6	9	4.1	215	100%
Recognition given to Optometrists as compared to physicians	32	14.8	68	31.6	70	32.5	45	20,9	215	100%
The number of patients you were required to see	34	15.7	79	36.7	56	26.0	46	21.4	215	100%
Your military pay and allowances for your grade and length of service	9	4.1	37	17.2	84	39.0	85	34.8	215	100%
Assistance and cooperation received from your ophthalmologist	74	36.2	60	24.5	50	24.5	20	9.8	204	100%
Education or training received from your ophthalmologist	31	15.8	56	28.5	48	24.4	61	31.1	196	100%
The numerous types of visual problems you were able to see or study	90	41.8	90	41.8	28	13.0	7	3.2	215	100%
The quantity and types of pathology you were able to see	96	44.6	73	33.9	33	15.3	13	6.0	215	100%
The opportunity to improve your Optometric skills and proficiency	63	29.3	81	37.6	47	21.8	24	11.1	215	100%

The question then arises, if they liked the Army this much, why did they get out? From the following table I think we can see the following:

1. Discrimination against the profession by not receiving professional pay, optometrists being the only core profession subject to the doctors draft law that does not receive this pay.
2. Insufficient pay and allowances, combined with the patient load they were required to see should command a much higher renumeration in civilian practice for less work.
3. Non optometric duties, a feeling that the army had taken them to do a specific job, there were patients waiting to be seen and they were off doing an administrators job, not what they could do best, optometry.
4. The military system of rank, that a professional man involved in direct patient care should be treated as a professional, not by the recognized award system of the organization.
5. A lack of personal freedom, the fact of travel limits, signing in and out, leave time or priority being determined by rank, not the desires of the individual.
6. Separation from family ranked high also, much higher than the possibility of a combat tour, which itself was the most important reason for almost 40%.

Table 31

AN EVALUATION OF THE IMPORTANCE OF WHY THEY DID NOT REMAIN IN THE ARMY

	Very important		Somewhat important		Not important	
	N	%	N	%	N	%
Insufficient pay and allowances	150	69.7	53	24.6	12	5.5
The fact that you did not receive "pro" pay	163	75.8	42	19.5	10	4.6
The time necessary to advance in rank	64	29.8	103	47.9	48	22.2
Lack of professional recognition	73	38.6	99	46.6	43	20.0
Poor working conditions	35	16.2	100	46.5	80	37.2
Frequency of moves	76	35.3	67	31.1	72	33.4
Location of military installations	39	18.2	101	47.0	74	34.4
Separation from family	105	48.8	53	24.5	57	23.7
Heavy patient load	56	30.0	102	47.5	57	23.7
Non-optometric duties	117	54.4	66	31.3	33	15.3
Ophthalmology relations and supervision	61	28.3	84	39.0	70	32.5
The hierarchial system of rank	110	51.2	59	27.4	46	21.3
A lucrative practice was waiting back home	38	17.7	41	19.0	136	63.2
A lack of personal freedom	98	45.5	92	42.7	25	11.6
The possibility of combat tour	81	37.6	60	27.8	74	34.4
Poor professional leadership	65	30.9	92	42.7	58	26.9
Many people consider the professional soldier a second class citizen	14	6.4	55	25.5	146	67.9
Limited non-military social activities	24	11.1	66	31.3	124	57.6

N = 215 % = 100

When asked to list the three most important reasons why they left the service, the number one reason (51%) was insufficient pay and allowances, second was the fact that they did not receive professional pay, third was the lack of professional freedom followed closely by frequency of moves, separation from family and non-optometric duties. Numerous other reasons were given, primarily having to do with conditions of professional practice and the structured system of the organization but none in sufficient quantity to set a trend. Although not listed among the most important reasons for leaving the service, the fact that 116 of the 174 wives held unfavorable opinions of a military career undoubtedly had a great deal to do with the decisions. Six listed the wife's opinion of the Army as the number one reason for separation. Percent wise this is insignificant, but the fact that 66.66 percent of the wives were against a career should be an indication as it is with industry - make the wife happy and the employee is secured.

An interesting analysis is to read what this group feels would be necessary for them to return for a career. This was an open-ended question and therefore quoted percentages require some interpretation and generalizing to apply them to a total population. Of those who responded, 14.4 percent stated that there were no changes that would be sufficient for them to return to active duty with the exception of an all-out declared war. Higher pay was stated as mandatory by 48.8 percent with 39.0 percent insisting on professional pay. Others of significance by the number of times noted are:

Elimination of non-optometric duties	21.4%
Professional autonomy in clinic operation and patient care	15.3%
Establishment of an Optometric Corps	14.8%
Credit in pay for education past the baccalaureate degree	11.6%
More decision in career planning and next assignment	12.6%
More time for each patient (or less patients)	11.1%
Faster (comparable) advancement in rank	11.1%

with the remainder of those obtaining a significant number of responses were dealing with patient care, scope of practice, professional freedom and improved living conditions.

These suggestions/recommendations could be met without too much difficulty and have been met for other professions on the part of the Army. Discrimination against the profession should be eliminated particularly in pay, and autonomy and freedom of practice, however the establishment of an Optometry Corps would prove costly in removing experienced officers from clinic management and patient care. Rank in all other branches (non-medical/patient care officers) denotes experience and young officers with more rank than experience can be a source of constant problems to themselves and to the army. This leads to the dual ladder concept of paying for services rendered without making it a command position.

The elimination of all non-optometric duties particularly AOD is not good as it is through this duty that a young officer learns how the organization (Army) functions. Any time, however, administrative duties interferes with or delays patient care, it should be eliminated, at least for the time being. It was mentioned several times that there are bad assignments which must be provided service, however there are good assignments and to get one of the good assignments, one should be expected to "pay his dues" in the bad assignment but rewarded with one of the choice ones.

This writer does not now and never intends to imply that the position of Military Optometrist should be made so attractive that a career officer would be attracted who does not have that measurable quality of duty, honor and love of country, which is in itself, a measure of reward for services rendered.

CONCLUSIONS

The meeting of the profession of Optometry and the United States Army has in the opinion of this writer been beneficial to both, in more ways than are apparent on the surface.

Optometry has gained in prestige, respect, and in the process has enlightened a large segment of the population to the capabilities of the profession. Young optometrists, entering the Army immediately following graduation, have had their knowledge increased, outlook broadened and have gone into practice in the civilian population with increased expertise and are providing better visual care to the citizens. Through the interprofessional relationships, optometry has gained in peer acceptance causing the establishment of multidiscipline health care centers that not many years ago was totally unacceptable.

The Army has gained by having the finest visual care provided any Army in the world today. The quality of visual care provided the soldier and his dependents has never been finer than that given the past five years. For the first time in any army in history, visual care and fabrication of spectacles has been provided for the front line troops, helping keep the combat strength of the line units high. Optometrists in the aeromedical research have provided significant contributions in the areas of lighting, visability in air craft, safety from increased vision and visability and protection from eye hazards.[25.] Optometrists today are in lazer research, in the Army Environmental Research Agency in occupational vision and in basic vision research. Optometrists are also today in the optical tracking and firing devices. The association of optometry and the Army has been good, for both.

However, when a profession and a bureaucracy meet, each has to yield some in order to have a successful partnership. The military has touched some sore spots with the professional.

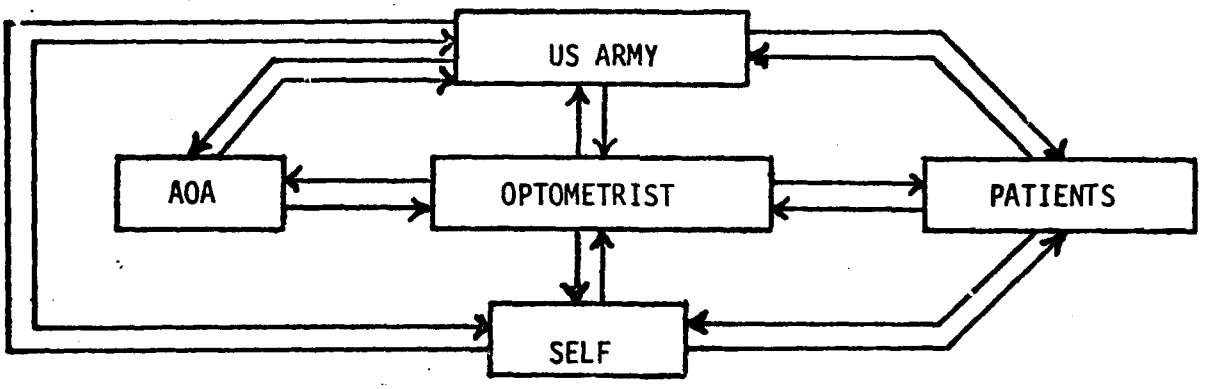
1. Having an independently trained, autonomous professional, under the supervision of another profession.
2. An autonomous professional, managed or being under the administrative control of a non-member of the profession.
3. Causing the professional to always be under the pressure of quality versus quantity.
4. Not giving the professional pay to the optometrists as other core professionals receive.
5. Demanding of the professional that he be a soldier first, and an optometrist second.
6. Demanding that the optometrist be a part-time administrator or perform other non-optometric duties on a routine basis, AOD, pay officer, officer of the guard, narcotics inventory, etc.
7. Insisting that the professional conform to the organization, club membership, participation in ceremonies, etc.
8. Not providing in pay, recognition of advanced education beyond the baccalaureate degree.

The Army has done other things though to recognize the optometrist as a professional.

1. They are included in the Doctors Draft Law, a means of acquiring health professionals for the military service.
2. Optometrists are commissioned officers, recognizing the status of the profession.
3. Optometrists have been provided the finest equipment that can be obtained.
4. Created the team approach of ophthalmology and optometry to provide the finest total care in the world today.
5. Provided support for visual care by providing high quality frames and lenses, and greatly expanding optical facilities to produce better and faster service.

These strains of recognition/non-recognition must be reduced if the Army is ever to attain a sufficient quantity of Optometrists in a career or regular Army status.

The military professional man is in a unique position in the military system. He has allegiances to more than the organization he is serving. The Profession, as represented in this study by the American Optometric Association, the organization represented by the Army, and his patients who are part of the organization and vice versa, and a responsibility to himself.



The Army also has the responsibility to follow its own policies/programs in retention. There are specific out processing directives to be followed prior to any soldiers separation from active duty (exceptions to this are those discharged other than honorably upon completion of obligation). One part of this is an explanation of the value and benefits of a Military career. In answer to this question of the "re-up" talk, the following responses were given.

Table 32

Did you get a "re-up" talk prior to separation?	N	%
Yes	64	30
No	150	70

If you did get a re-up talk, was it by an optometrist?	N	%
Yes	36	57.1
No	27	42.9
Totals	63	100.0%

It is fairly apparent that (1) the Army is failing in its utilization of this routine retention method. Apparently, the program for optometry officer rentention is not being carried out, certainly among these respondents, or (2) there was a lot of on the spot screening done by the immediate supervisors of (1) the Army does not want/need this individual or (2) we could never keep this individual regardless of what is said. A considerable number of these officers are not supervised by a senior optometry officer and it possibly would be to the Army's advantage to utilize the assistant to the Chief, Optometry Section in the Surgeon Generals Office, to determine the desirability of these isolated officers and make a "recruiting trip" prior to the individuals ETS. Senior officers throughout the various posts might also make trips for this purpose.

Optometry as a profession is more comparable with the Dental Profession than they are with the Medical Profession. Optometrists and Dentists generally are able to keep "regular" office hours, keep appointments and do not have "death" per se involved to the extent that physicians do. Dentists specialize in the different phases of Dentistry and limit their practice to this specialty. Optometrists in a lesser degree also specialize, however with optometrists this is within a general optometric practice although some do limit their practice to developmental vision, contact lenses, industrial vision, etc.

Table 33

Optometrists, specializing, but less than full time

Specialty	N	%
Contact lenses	206	96
Visual training	91	42
Subnormal vision	43	20
Industrial vision	45	20
Occupational vision	39	18
Reading training	10	05
Pedioptics	42	20
Gerioptics	34	16
Developmental vision	58	27

In the Army, the Regular or Standing Army, that core from which any expansion is based, has been set by The United States Congress, a certain amount of officers of any specialty. The Optometry Section of the Medical Service Corps has authorized 91 Regular Army officers.

Table 34

Optometry and the Regular Army

Rank	AUTHORIZED = 91		ACTUAL = 50	
	N	%	N	%
Colonels	7	8	4	4.4
Lt. Colonels	13	14	13	14.2
Majors	17	19	26	28.6
Captains	21	23	7	7.7
Lt. (first & second)	33	36	0	0.0
TOTALS	91	100	50	54.9

Lets consider the Dentists in the Regular Army. The Dental Corps is authorized 834 regular Army Officers and they actually have 674 or 80.8 per cent while the Optometry Section is only authorized 91 and can manage only 50 of these. Why? There must be several reasons why the Dentists can get 26 percent more of their authorization. The statistics in this case do not give the true picture because the number of Regular Army Dentists is thirteen and one half times larger than optometrists while their authorization is only nine times larger. If the dentists can get 674 officers to go Regular Army, optometry should be able to get more than 50. Listed below are a few differences in the professional practice that dentists have that optometrists do not have. Lets look at a few of these differences and then compare them to the things that optometrists want.

1) Dentists have their own Corps.

2) They do not have administrative duties other than those associated with their own clinics.

3) They receive professional pay.

4) They receive pay for education above the baccalaureate degree.

5) Their supervision is by their own profession.

6) They are autonomous in clinic operation and patient control.

7) They have their own paramedical personnel.

8) They are promoted on a fully qualified basis, not best qualified and are judged and compete against peers of their profession.

Optometrists want, as concluded from this survey, recognition in the form of pay, rank and privileges, that they are an autonomous core profession in the health care field; professional pay as a profession drafted under the Doctors Draft Law; an Optometry Corps, which is another form of recognition of the autonomous profession; credit, in pay, for education as other core professionals; comparable advancement in rank with other health professionals; the elimination of administration duties not related to the Optometry clinic; a sufficient staff of optometrists to eliminate (1) the long waiting periods for patients and (2) the need to provide limited examinations as are necessary in basic training centers; comparable educational leaves as other core professionals receive; the opportunity to provide the full scope of visual care he is qualified to give; ancillary personnel specifically trained to assist so that better patient care can be given; but most of all, I conclude, recognition of what an optometrist is, what he can do, be allowed and provided the equipment and facilities to do it and be compensated for this in pay.

APPENDIX A

UNIVERSITY OF PITTSBURGH
Graduate School of Public Health

AN ATTITUDE STUDY OF EX-MILITARY OPTOMETRISTS

1. Dates of active duty _____ (month - year) to _____ (month - year)

2. What was your rank upon entering the Army? __1__ 2Lt. __2__ 1Lt. __3__ Cpt.

3. Rank upon separation from active duty? __1__ 1Lt. __2__ Cpt.

4. Are you now in active Army Reserve? __1__ Yes __2__ No

5. Which Army area(s) were you stationed in while stateside?
   __1__ 1st Army __3__ 4th Army __5__ 6th Army
   __2__ 3rd Army __4__ 5th Army __6__ No stateside service

6. Which Army area(s) were you stationed in while overseas?
   __1__ Vietnam __4__ Europe __7__ Hawaii
   __2__ Korea __5__ Okinawa __8__ South America
   __3__ Japan __6__ Alaska __9__ No overseas service

7. Did you feel that you were part of the military family? __1__ Yes __2__ No

8. Did you have post housing? __1__ Yes __2__ No

9. Did you belong to the Officers' Club? __1__ Yes __2__ No

9a. If YES, did you use the facilities of the Officers' Club?
   __1__ Frequently __2__ Occasionally __3__ Never

10. Were you "pressured" to join the Officers' Club? __1__ Yes __2__ Somewhat __3__ No

11. Were you "pressured" to make donations to military charities? (AER, United Fund)
   __1__ Yes __2__ Somewhat __3__ No

12. In your opinion, were the post facilities for recreation and hobbies:
   __1__ Excellent __2__ Good __3__ Fair __4__ Poor __5__ Don't know

13. What was the value of the post exchange to you?
   _____ High value, saved considerable money on purchases
   _____ Some value, saved money on basic items
   _____ Low value, usually shopped in the civilian community

14. What was the one most disagreeable thing about the PX?
   __1__ Too crowded
   __2__ Too expensive
   __3__ Poor quality
   __4__ Limited selection
   __5__ Poor facilities
   __6__ Indifferent sales personnel
   __7__ Insufficient checkout lines
   __8__ Lack of latest fashions
   __9__ Other _____

15. What value was the post commissary to you?
   __1__ High value, saved considerable money on purchases
   __2__ Some value, saved money on basic items
   __3__ Low value, usually shopped in the civilian community

16. How many optometrists were in the clinic you were assigned? (excluding RVN) _____

17. What was your normal patient load per day? (excluding RVN) _____

18. Did you have sufficient ancillary personnel? 1 Usually 2 Sometimes 3 Never

19. Please rate each of the following items as you normally saw them during your tour. (Try to omit the exceptional or isolated case, i.e. one bad lens, one bad frame)

Circle one number for each item

	Excellent	Good	Fair	Poor	Very poor
a. Your Optometry Clinic (the building, fixtures, maintenance, efficiency, etc.)	1	2	3	4	5
b. The Optometric equipment provided for your use	1	2	3	4	5
c. The standard military frame	1	2	3	4	5
d. The quality of military lenses	1	2	3	4	5
e. Quality of military optical laboratory services	1	2	3	4	5
f. Quality of the PX optical concession	1	2	3	4	5
g. Patient attitude toward Optometry	1	2	3	4	5
h. The quality of Optometric care provided in your clinic	1	2	3	4	5
i. Your usual duty hours	1	2	3	4	5
j. The rapport you were able to reach with your patients	1	2	3	4	5

20. In your practice of Optometry in the Army, did you:

Circle one number for each item

	Always	Usually	Occasionally	Never
a. Have the opportunity to be original..	1	2	3	4
b. Have a chance to exercise leadership.	1	2	3	4
c. Have the opportunity to experiment with various techniques/methods.....	1	2	3	4
d. Have the opportunity to work closely with other disciplines	1	2	3	4
e. Have the opportunity to work closely with other optometrists	1	2	3	4
f. Have freedom from pressure to conform in professional standards	1	2	3	4
g. Have social standing and prestige among other groups	1	2	3	4
h. Have the opportunity to use your education to the fullest	1	2	3	4

21. Was your immediate supervisor an:
1 Optometrist 2 Ophthalmologist 3 Otolaryngologist 4 Other Physici

22. The next higher supervisor was an:
1 Optometrist 2 Ophthalmologist 3 Otolaryngologist 4 Other Physici

23. Were you required to perform "quickie" exams?
1 Always 2 Often 3 Occasional 4 Never

24. Did you have time to perform a good visual examination, although without frills?
__1__ Always __2__ Often __3__ Occasionally __4__ Never

25. Were you prohibited from doing additional procedures? (skills, keratometer, slit lamp, etc.)
__1__ Always __2__ Often __3__ Occasionally __4__ Never

25a. If answer is Always, Often or Occasionally, was this due to lack of:
__1__ Equipment __2__ Time __3__ Other factors

26. Were you coerced/ordered to eliminate certain findings/procedures from your routine examination?
__1__ Yes __2__ No

26a. If YES, was this done by an:
__1__ Optometrist __2__ Ophthalmologist __3__ Otolaryngologist
__4__ Other Physician __5__ Administrative Officer

27. Were you ordered/directed, NOT TO PRESCRIBE certain types of lenses? (i.e. multifocals, tints, bifocals for children, etc.)
__1__ Yes __2__ No

27a. If YES, was this done by an:
__1__ Optometrist __2__ Ophthalmologist __3__ Otolaryngologist
__4__ Other Physician __5__ Administrative Officer

28. Did you fit contact lenses? __1__ Yes __2__ No

28a. If YES, did you fit enough contact lenses to:
__1__ Increase proficiency __2__ Maintain proficiency
__3__ Lose Proficiency

29. Did you give Visual Training, other than home training? __1__ Yes __2__ No

30. Do you feel that Optometry Office could pull AOD? __1__ Yes __2__ No

31. Were non-optometric duties other than AOD:
__1__ Frequent __2__ Occasional __3__ Seldom __4__ Never

32. Was your military service valuable to you professionally?
__1__ Great value __2__ Some value __3__ Little value

33. Do you feel that your military services actually hindered your professional career? __1__ Yes __2__ No

34. Have you ever considered returning to active duty with the Army?
__1__ Yes __2__ Not seriously __3__ No

35. Did you get a re-up talk prior to separation? __1__ Yes __2__ No

35a. If YES, was this by an Optometrist?
__1__ Yes __2__ No

36. Are you from a military family? __1__ Yes __2__ No

37. Is your father an Optometrist? __1__ Yes __2__ No

38. How satisfied were you with each of the following conditions or situations?

Circle one number for each item

	Well satisfied	Somewhat satisfied	Mildly dissatisfied	Very dissatisfied
a. The opportunity to provide high quality visual care to your patients	1	2	3	4
b. The opportunity to maintain a good doctor-patient relationship	1	2	3	4
c. Recognition given to Optometrists as compared to physicians	1	2	3	4
d. The number of patients you were required to see	1	2	3	4
e. Your military pay and allowances for your grade and length of service	1	2	3	4
f. Assistance and cooperation received from your ophthalmologist	1	2	3	4
g. Education or training received from your ophthalmologist	1	2	3	4
h. The numerous types of visual problems you were able to see or study	1	2	3	4
i. The quantity and types of pathology you were able to see	1	2	3	4
j. The opportunity to improve your Optometric skills and proficiency	1	2	3	4

39. Listed below are some items that military Optometrists see as important problems. Please indicate the degree that you considered each in your decision to leave the Army.

	Circle one number for each item			
	A very serious problem	A fairly serious problem	A problem but not serious	Not a problem
a. The number of patients for which you had to assume responsibility	1	2	3	4
b. Restrictions on the scope of your practice	1	2	3	4
c. Having ophthalmologists as supervisors	1	2	3	4
d. The inability to follow a patient following your initial examination	1	2	3	4
e. Even though you possessed the health record, being unable to find the previous Rx	1	2	3	4
f. Utilization of screening techniques in lieu of a full visual examination	1	2	3	4
g. Military patients become repetitious and offer no challenge	1	2	3	4
h. Not being able to see children under age 6 or 7	1	2	3	4
i. You did not have the equipment to do what you considered best for the patient	1	2	3	4
j. Not having time to do an adequate or complete visual examination	1	2	3	4
k. Paperwork, spending a large amount of time not requiring your optometric skills	1	2	3	4
l. The fact that you had to wear a uniform during patient care	1	2	3	4

40. Listed below are some of the characteristics of military life and professional practice for an Army officer. What was your feeling about each of these?

	Circle one for each item			
	Liked very much	Liked somewhat	Of no importance	Did not like
a. Camaraderie	1	2	3	4
b. Chance to travel	1	2	3	4
c. Group practice	1	2	3	4
d. Regular working hours	1	2	3	4
e. Professional experiences	1	2	3	4
f. Security	1	2	3	4
g. Chance for post graduate education .	1	2	3	4
h. No financial investment required ...	1	2	3	4
i. Guaranteed income	1	2	3	4
j. Retirement benefits	1	2	3	4
k. Second career at a young age	1	2	3	4
l. Paid vacation and holidays	1	2	3	4
m. Social and cultural activities	1	2	3	4

41. Please evaluate each of the following reasons why you DID NOT remain in the Army for a career. Evaluate each by its importance to you.

	Circle one for each item		
	Very important	Somewhat important	Not important
a. Insufficient pay and allowances	1	2	3
b. The fact that you did not receive "pro" pay	1	2	3
c. The time necessary to advance in rank	1	2	3
d. Lack of professional recognition	1	2	3
e. Poor working conditions	1	2	3
f. Frequency of moves	1	2	3
g. Location of military installations	1	2	3
h. Separation from family	1	2	3
i. Heavy patient load	1	2	3
j. Non-optometric duties	1	2	3
k. Ophthalmology relations and supervision	1	2	3
l. The hierarchial system of rank	1	2	3
m. A lucrative practice was waiting back home	1	2	3
n. A lack of personal freedom	1	2	3
o. The possibility of combat tour	1	2	3
p. Poor professional leadership	1	2	3
q. Many people consider the professional soldier a second class citizen	1	2	3
r. Limited non-military social activities	1	2	3

42. Please list in order, the three most important reasons why you got out of the Army. If they are in the above list, you may use the alphabetical notation.

1. _____
2. _____
3. _____

43. How did your wife feel about you remaining in the Army? (If single, omit)

__1__ favorable __2__ unfavorable __3__ no opinion

44. Year Optometric degree received 19____

45. College or University conferring degree _____

46. What was your Optometric experience prior to military service? Circle only one type. If more than one type, circle the longest practice.

__1__ None
__2__ Solo practice
__3__ Associate practice
__4__ Group practice (3 or more optometrists)
__5__ Group practice (Multidiscipline)
__6__ Employed by an optometrist
__7__ Employed by an ophthalmologist
__8__ Employed by a firm
__9__ Other _____

47. What type of practice are you in now?

1	None	5	Group practice (Multidiscipline)
2	Solo practice	6	Employed by an optometrist
3	Associate practice	7	Employed by an ophthalmologist
4	Group practice (3 or more optometrists)	8	Employed by a firm
		9	Other _____

48. Approximately how many hours do you spend in your office per week? _____ Hours

49. To the nearest thousand, what is the population of the city in which you now practice? _____

50. In which of the following specialties do you practice? Circle all which apply.

1	Contact lenses	4	Industrial vision	7	Pedioptics
2	Visual training	5	Occupational vision	8	Gerioptics
3	Subnormal vision	6	Reading training	9	Development vision

51. What was your marital status at time of separation from active duty?

1 Single 2 Married 3 Divorced 4 Separated

52. What is your religion?

1 Protestant 2 Catholic 3 Jewish 4 Other 5 None

53. Please indicate your 1970 income category.

1	Under $3,000	4	$7,500 to $9,999	7	$15,000 to $17,499
2	$3,000 to $4,999	5	10,000 to 12,499	8	17,500 to 19,999
3	5,000 to 7,499	6	13,000 to 14,499	9	20,000 or more

54. Now that we have spent all of the preceeding time on why you got out of the Army, what factors or changes would have been essential for you to remain in or return to the Army for a career.

_____

_____

_____

_____

APPENDIX B

NOTES

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